ROCKSIDE CHIROPRACTIC AUTO ACCIDENT FORM

Date of Accident: _____ **Time Of Accident**: _____

Were you the: Driver Passenger (Front Rear) Pedestrian **How many people were in your vehicle?** _____

Describe the accident in your own words:

_____

_____

_____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

Accident Site:

Location of the accident: _____

City/State: _____

Nearest intersection: _____

Driving conditions: Dry Wet Icy Other: _____

Which direction were you heading: _____

Speed you were traveling: _____

Vehicle:

Make and model of the vehicle you were in: _____

Were you wearing a seatbelt? Yes No **if yes, what type?** Lap Shoulder Both

Did your seat have a headrest? Yes No **if yes, what was the position of the headrest?** Low Midposition High

Did the airbags inflate? Yes No

Other Vehicle:

Make and model of the other vehicle: _____

Which direction was the other vehicle headed? _____

Speed other vehicle was traveling? _____

Impact:

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No **if yes please explain:** _____

_____

Did any part of your body strike anything in the vehicle? Yes No

If yes, explain: _____

Was the impact from: Front Rear Left Right Other: _____

At the time of impact were you: looking straight looking left looking right looking up looking down

Were both hands on the wheel? Yes No **if no, which hand was on the wheel?** Right Left

Was your foot on the brake? Yes No **if yes, which foot was on the brake?** Right Left

Were you: Surprised by the impact Braced for the impact

Were you unconscious immediately after the accident? Yes No **if yes, for how long?** _____

Please describe how you felt immediately after the accident? _____

_____

Treatment:

Did you go to the hospital? Yes No

When did you go? Immediately after the accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private Transportation

Name of the hospital: _____

City: _____

Diagnosis: _____

Treatment received: _____

Were x-rays, MRI or CT scan taken: Yes No

Symptoms/Injuries:

Have you been able to work since the injury? Yes No **How many work days have you missed?** _____

Prior to the accident were you able to perform all you regular work duties? Yes No

Have you had any of the following symptoms since your injury, please check all that apply:

- ○ Arm/ Shoulder pain
- ○ Back pain
- ○ Back stiffness
- ○ Chest pain
- ○ Dizziness
- ○ Ear buzzing
- ○ Ear ringing
- ○ Fatigue
- ○ Feet/ Toe numbness
- ○ Hand/ Finger numbness
- ○ Headaches
- ○ Irritability
- ○ Jaw problems
- ○ Leg pain
- ○ Memory loss
- ○ Nausea
- ○ Neck pain
- ○ Neck stiffness
- ○ Shortness of breath
- ○ Sleep difficulty
- ○ Stomach upset
- ○ Tension
- ○ Vision blurred

Are these conditions getting worst? Yes No

Rate the severity of your pain from a scale from 1 (least pain) to 10 (severe pain) _____

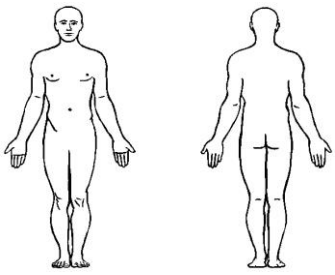
Type of pain: Sharp Aching Cramps Dull Shooting Throbbing Numbness Burning
Swelling Tingling Stiffness Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with you: Work Sleep Daily Routine Recreation

Activities or movements that are more painful to perform: Sitting Standing Bending Lying down Walking



Mark an **X** on the picture where you continue to have pain, numbness, or tingling.

I certified that the above information is correct to the best of my knowledge

Patient Signature: _____ **Date:** _____